EUGENE B. NICHOLS, D.M.D.
508.543.2233

Family Dentistry

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

TO: _____ (your former dentist name and address)

_____

_____

I (print patient or guardian's name) _____, hereby authorize the doctor and staff of (your former dentist)_____dental office to release records or knowledge concerning the dental health of

[patient(s) name] _____ to:

Eugene B. Nichols, DMD
15R Mechanic Street
Foxboro, MA 02035
FAX 508-543-2201

I specifically request that you release copies of:

__X__ All x-rays __X__All treatment notes __X__ Full mouth Perio Charting

Signed (patient or guardian name)_____

Print name (patient or guardian name)_____

Date:_____